Strategies for Incremental Expansion of Access to Care

Steps to Universal Coverage

American College of Physicians
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Executive Summary

Despite a number of favorable economic trends—7 million new jobs during the past 5 years, strong corporate profits, low inflation, low growth in private health insurance premiums, and substantial increases in federal and state government revenues—the number of uninsured continues to increase. During 1996, an estimated 41.4 million nonelderly Americans, *17.6% of the population below age 65*, were uninsured. The problems of the uninsured will not self-correct even under the most favorable economic conditions.

The American College of Physicians remains committed to the goal of health care coverage for all Americans. However, like other large social issues, progress towards that goal is likely to be achieved in a series of steps. Recent history suggests that the American people will support bipartisan initiatives that address specific problems and extend coverage to segments of the uninsured population such as low-income children.

Strategies for Incremental Expansion of Access to Care presents ACP recommendations for a series of incremental steps that would provide health coverage for most low-income Americans and about half of the total number of uninsured. Political reality suggests that support for any strategy must be bipartisan and that successful proposals are likely to:

- Build on existing programs, not offer a large, new government program.
- Establish broad federal rules governing program benefits and standards, with state flexibility in the design and implementation of programs.
- Target the population below 200% of the poverty level.
- Derive funding from "indirect" sources, such as tax credits and savings in related programs, and from expansions of existing revenue sources, such as tobacco taxes, but not from a large, general tax increase.
- Assure that coverage or options available to insured people are not diminished or perceived to diminish.

The College proposes several options for expansions of health care coverage; they can be implemented collectively or individually. Issues of program design and implementation are critical to success, so phasing in these proposals over several years is appropriate. Options include:

- Aggressive efforts to enroll children currently eligible for Medicaid but not receiving benefits.
- State flexibility to extend Medicaid coverage to all adults up to the poverty level.
- Refundable tax credits to help adults between the poverty level and 200% of the poverty level purchase private health insurance coverage.
- Temporary federal financial assistance for workers between jobs to make COBRA extensions of employer coverage affordable.

This Policy Paper estimates the costs of these proposals and presents several approaches to financing, including tobacco-tax revenue from pending settlement talks with the industry; federal and state savings in the existing Medicaid

program, as have been achieved in several states under waiver programs; and the conversion of a portion of federal "disproportionate share" payments currently made under Medicare and Medicaid into individually based subsidies.

Strategies for Incremental Expansion of Access to Care

Steps to Universal Coverage

Preface

The American College of Physicians is committed to reaching the goal of health care insurance coverage for all Americans. The failure of our public and private systems to provide health care coverage for all remains the most critical health challenge facing the nation. Despite extraordinary economic growth and burgeoning federal and state government revenues, one out of six nonelderly Americans is uninsured. The majority of Americans receive coverage through their employers, individually purchased coverage, and public programs such as Medicare and Medicaid — and their care can be the best in the world. It is well documented, however, that the uninsured receive fewer health care services, are sicker, and face higher mortality rates than those who have insurance.[1] It is this impact on health status that has generated the ongoing concern of the American College of Physicians. The College remains committed to universal coverage — that is, that all Americans must have health care coverage for their medical needs.[2]

Although our goal is universal coverage, that goal realistically may be achieved in a series of steps to expand access to care over a number of years. This is not unlike the progress made in other major social policy areas—for example, civil rights, gender equality, and environmental protection—in which advances were made through legislation and other steps taken over time. Although the American public does not seem to support major shifts of policy or large expansions of government's role, recent experience has shown that the public will support, and Congress will pass, incremental changes. The expansion of Medicaid beyond the beneficiaries of Aid to Families with Dependent Children, the Health Insurance Portability and Accountability Act of 1996, and the Children's Health Insurance Program of 1997 are all examples of important steps to broaden coverage, taken with bipartisan support, and all are opportunities to build on for future initiatives.

In this Policy Paper, the College lays out an agenda for further progress towards our goal of universal coverage. The initiatives we recommend are politically practical and substantively meaningful next steps that would provide coverage for all low-income households and reduce the total number of the uninsured by half. We welcome proposals for federal, state, and local initiatives and hope to work with others to expand coverage.

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[1]Blumberg LJ, Liska DW. The Uninsured in the United States: A Status Report. The Urban Institute, 1996. Donelan K, et al. Whatever happened to the health insurance crisis in the United States? JAMA. 1996;276:1346-50.

[2]Universal Coverage: Renewing the Call to Action. Philadelphia: American College of Physicians, 1996. Earlier ACP policy: access to health care. Ann Intern Med. 1990;112:641-61. Universal insurance for American health care. Ann Intern Med. 1992;117:511-9.

Background

The health care delivery system has experienced substantial change during the past 5 years. These changes include the ascendancy of managed care and slower growth in private health care expenditures. The growth in managed care has substantial implications for the care delivered to patients with health insurance. Yet, despite the substantial changes in the nature and style of care delivered to patients with insurance, they continue to represent a declining share of the American population. Even as these important changes have transpired, the percent of Americans without health insurance continued to rise. During 1996, an estimated 41.4 million nonelderly Americans—some 17.6% of the nonelderly population—were uninsured.[3]

The high, and rising, share of Americans without insurance has persisted despite robust growth in the economy and unemployment rates reaching a 24-year low. Between 1993 and 1996, the economy produced nearly 7 million new jobs. Yet, despite this impressive economic performance, the percent of all Americans without insurance *increased* from 15.3% in 1993 to 15.6% in 1996. This most recent experience indicates that economic expansion coupled with low growth in inflation and the cost of private health insurance by itself will not reduce the share of Americans without health insurance. Though incremental steps to extend coverage have recently been adopted, without subsequent governmental intervention the number of uninsured will continue to rise. An economic downturn would, of course, exacerbate this trend.

The traditional means of financing care for the uninsured, through generating profits from more generous health plans, is increasingly at risk, because the growth in payments from private health plans to health care providers has slowed substantially. Moreover, the Balanced Budget Act of 1997 would reduce the growth in Medicare and Medicaid spending by nearly $130 billion over the next 5 years. Cost-containment efforts in both the public and private sector will slow the growth in provider revenues, placing added pressure on providers seeking to subsidize free care provided to the uninsured. This new financial pressure will occur during a period when the share of uninsured Americans continues to rise and, along with it, an increasing demand for uncompensated care.

Though the Congress and the President could not reach agreement concerning a comprehensive approach to covering the uninsured during the 103rd and 104th sessions of Congress, several incremental options were adopted during the 1990s. Of note is the recently passed Children's Health Insurance Program (CHIP), which authorized an expansion of coverage for uninsured children starting in October 1997. Collectively, these approaches have moderated, and are anticipated to moderate, the growth in the percent of Americans without health insurance. However, without on-going efforts to extend health insurance coverage, all signs point to the continued rise in the share of Americans without health insurance.

[3]Tabulations from the Current Population Survey, March 1997. The survey questions are intended to estimate the number of Americans uninsured all year. However, many researchers believe the estimates more accurately reflect the number uninsured at a moment in time—for instance, during a typical month. This total excludes an estimated 300,000 elderly Americans without insurance. Among all Americans, approximately 15.6% of the population was uninsured during 1996.

Incremental Reforms: A Brief Review of Steps to Date

Both the federal government and individual states have actively pursued incremental efforts designed to expand health insurance to low-income populations. These approaches are outlined briefly below:

- *State Expansions of Medicaid*—To date, the Administration has approved several Section 1115 Medicaid Research and Demonstration Waivers; 13 states have implemented their programs. These 1115 waivers are intended to allow the states to experiment with a variety of alternative payment and financing mechanisms. These experiments have included expansion of coverage to the uninsured. However, each of the state experiments must be "budget neutral"; that is, federal spending cannot be higher under the waiver. This means that states seeking to extend coverage to the uninsured must generate savings sufficient to cover the new populations at no new federal cost. To achieve these savings, most states have used the waivers to extend managed care to segments of their current Medicaid population.

  Several evaluations indicate that, relative to fee-for-service plans, managed care can reduce spending by approximately 20%.[4] In some cases, managed care savings have been augmented with rechanneling disproportionate share spending into health insurance. Many states have used these savings to extend coverage to uninsured state residents who are not Medicaid eligible. For instance, states such as Massachusetts, Vermont, Oregon, and Delaware have broadly expanded health insurance coverage to previously uninsured residents below a defined percent of the poverty level. Massachusetts plans to direct savings generated through managed care into expanded coverage for nearly all residents living under 200% of the poverty level.[5] This would extend coverage to an estimated 160,000 state residents. Other states, such as Tennessee, have combined savings from managed care and disproportionate share dollars to extend coverage to the previously uninsured. Through June 1996, five states had extended health insurance coverage to over 550,000 persons previously uninsured through a combination of managed care savings and rechanneled disproportionate share spending. Expanded coverage in these states was accomplished without higher federal spending.[6]

  The 1115 waivers also provide some important lessons concerning program implementation. In some cases, such as Tennessee, implementation occurred very quickly, perhaps without sufficient planning needed to anticipate potential problems inherent in large-scale changes in the organization and delivery of services. Several problems with the implementation of the Tennessee waiver have been reported, including the assignment of eligibles to plans and low rates of provider payments that may have compromised access to care. Lessons from the implementation of the Tennessee waiver, however, have provided important lessons for other states seeking similar flexibility.

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[4]Congressional Budget Office, "The Effects of Managed Care and Managed Competition," Memorandum, February 1997.

[5]The 1997 poverty guidelines of the Department of Health and Human Service for the 48 contiguous states and the District of Columbia are $10,610 for a family unit of two, $13,330 for three, and $16,050 for four. Federal Register, vol. 62, no. 46, 10 March 1997.

[6]Unpublished data from state summaries, Health Care Financing Administration, 1997.

- *Federal and State Expansions of Medicaid*—During the late 1980s, the federal government expanded Medicaid coverage to certain low-income children and pregnant women. Under federal law, all children under age 6 and pregnant women living in families with income under 133% of the poverty level are eligible for Medicaid (states that had raised eligibility levels for pregnant women and children under age 6 to a higher level before 19 December 1989 were required to maintain that level). As part of the Omnibus Reconciliation Act of 1990, states were required to phase in coverage of children living in poverty born after 30 September 1983. By October 2002, all children under age 19 living in poverty will become eligible for Medicaid.

  In addition to the federal mandates, authorization was provided during 1989 and 1990 allowing the states to expand coverage for pregnant women and infants above the federal mandates. For example, the National Governors' Association reports that 34 states have expanded eligibility to 185% of the poverty line for these people. In addition, states may, with approvals from the Health Care Financing Administration under Section 1902(r)(2) of the Social Security Act, liberalize their income and asset testing used in Aid to Families with Dependent Children (now replaced by the Temporary Assistance for Needy Families program). This has allowed several states to expand Medicaid coverage to children living in families with incomes above the federally mandated levels.

  Several states also have expanded health insurance coverage for children through collaborative arrangements with the private sector. Some states, such as Alabama and Pennsylvania, have expanded coverage working through the Blue Cross Caring Program. Other states, such as Florida, are working with school districts to identify and provide health insurance to uninsured children. Nationally, over 900 school-based health centers are in operation.[7]

- *Post-Employment Continuation Coverage*—As part of the Consolidated Omnibus Budget Reconciliation Act (COBRA, PL99-272), employer-sponsored health insurance may be continued generally for up to 18 months under two qualifying events. The first event is involuntary or voluntary job separation; the second is family-related change stemming from divorce or legal separation from, or the death of, an insured worker. Under COBRA, eligible persons may continue to purchase their former insurance coverage at a premium up to 102% of its total cost. Despite the continuity and protection offered former workers and their families, relatively few qualified persons actually participate in the program, presumably because of its cost. Among those qualifying through job separation, 19% participated in the program, whereas a third of those qualifying through family-related events continued their coverage.[8]

- *Tax Deductibility of Health Insurance for the Self-Employed and the Tax-Free Medical Savings Account*—The federal government has also attempted to reduce the number of uninsured through the tax code. Under current law, the self-employed can deduct 40% of their health

[7]BNA, Health Policy Report, 11 August 1997, p 1273.
[8]Flynn, P. COBRA Qualifying Events and Elections, 1987-1991. Inquiry. Summer 1994;31:215. Flynn reports over 1.3 million participants in COBRA per year during this time period.

insurance premiums. The deductibility will increase to 80% by the year 2006. Increasing the tax deduction is one approach for extending coverage to the 3.1 million self-employed workers without health insurance (data from *Current Population Survey*, March 1996).

The government has also used the tax code to encourage the self-employed and employees in small businesses to purchase medical savings accounts (MSAs). With an MSA, an eligible worker (workers employed in firms up to 50) can establish a tax-free personal savings account to be used for qualified medical expenses. In this case, allowing workers to purchase insurance with pre-tax dollars is intended to increase the number of insured persons. However, as of September 1997, only 9720 taxpayers had established such accounts.

- *Health Insurance Portability and Accountability Act (HIPAA)*—In 1996, the Congress passed, and the President signed, legislation designed to reform significant portions of the health insurance marketplace. The HIPAA includes reforms for persons moving across group health insurance plans and for those moving between group and individual plans. In general, the HIPAA establishes limits on the length of pre-existing condition exclusions across group plans for qualified persons, and provides guarantee issue and renewal for qualified persons moving from the group to the individual market. Though the HIPAA does not specifically address the affordability of health insurance in the individual market, the Congressional Budget Office has estimated that the increased availability of insurance could extend coverage to approximately 550,000 otherwise uninsured persons.[9]

The Remaining Uninsured: A Demographic Profile

Though incremental reform efforts are proceeding at the federal, state, and local levels, over 41 million persons remain uninsured (Table 1). Over half of the uninsured live in "insurance families," that is, having an income below 133% of the poverty level.[10] Almost 30 million people, or more than 70% of the uninsured, are below 200% of the poverty level.

Table 1. Health Insurance Coverage of Nonelderly Population, by Insurance Household Income as Percent of Poverty Level, 1996.

% of Poverty Level	*Number Uninsured (millions)*	*Total Uninsured (%)*	*Within Income Category (%)*
0–100	17.7	35.7	42.9
101–133	4.7	32.4	11.3
134–200	7.5	25.7	18.0
201–300	5.4	14.0	13.0
301–400	2.7	8.6	6.7
>401	3.3	4.7	8.2
Total:	41.4	100	17.6

Data from *Current Population Survey*, March 1997. Percent of poverty level refers to health insurance household, not the broader Census family definition.

[9]Congressional Budget Office, "Letter to the Honorable Bill Archer," 1 August 1996, Washington, D.C.

[10]The concept of an insurance family differs from the family unit definition used by the Census. An *insurance family* constitutes only those family members that would likely be covered under a private health insurance policy. As a result, the term is more restrictive than the broader *Census family*, which could include other extended family members. For instance, a 30-year-old woman and her son living with the woman's parents could constitute a Census family but would count as two separate insurance families. The more restrictive definition results in a substantial increase in persons living at or near the poverty line.

Table 2. Uninsured Adults and Children (Millions), by Family Income as Percent of Poverty Level, Currently Eligible for Medicaid and CHIP.

% of Poverty Level	Uninsured Adults	Uninsured Children	Currently Eligible for Medicaid	Currently Eligible for CHIP*
0–100	12.1	5.7	5.0	0
101–133	3.3	1.3	0.6	0.5
134–200	5.4	2.0	0.3	1.5
201–300	4.2	1.2	0.1	0.1
301–400	2.2	0.5	0	0
>401	2.8	0.6	0	0
Total:	30.1	11.3	6.0	2.1

*Some children living in poverty who are uninsured could be included in CHIP. Data represent children eligible as of federal Fiscal Year 1998.

Among the low-income uninsured, approximately 8.1 million children are currently eligible for Medicaid or the new federal/state Children's Health Insurance Program (CHIP) (Table 2). This leaves approximately 20 million adults living in families under 200% of the poverty line without insurance. Some potential approaches for extending coverage to this population are examined below.

Incremental Health Care Reform Options

The history of health care policy is replete with proposals designed to provide health insurance coverage for all Americans. Though most Americans, as well as their elected officials, do not disagree on the merits of universal coverage, substantial disagreement exists concerning how the coverage would be financed and who would administer the program. To date, despite repeated attempts to provide universal coverage, the Congress and the President have failed to reach agreement on the key issues of financing and administration. Though disagreement exists concerning comprehensive reform efforts, the passage of HIPAA and CHIP indicates that the Congress and the President can agree on key issues of financing and administration of more limited and targeted efforts to expand health insurance.

This section presents a menu of additional incremental expansions that rely on the strategy employed in passing CHIP. These strategies include the establishment of broad federal guidelines for program eligibility and benefit design with state administration and implementation. Included among the state decisions is the use of private or state administered health insurance benefits. As a result, the broad rule-setting authority of the federal government in establishing the playing field would not result in a significant increase in the direct federal provision of health insurance benefits. By their very nature, the incremental proposals would generate incremental increases in federal expenditures. Where required, new federal expenditures would, by law, be capped, and financed through a combination of savings in health care costs generated by the states and selected excise taxes, as opposed to increases in income or payroll taxes. Clearly, as the experience with CHIP revealed, enacting additional incremental health care reforms will require bipartisan support.

A central feature in the design of the incremental approaches presented below is the targeting of federal dollars for the uninsured. In each case, the program design is intended to identify and enroll eligible and uninsured Americans, not to disrupt the health insurance arrangements and choices presented to those with health insurance.

General Program Descriptions

This section outlines several options that build on the incremental reform efforts discussed above. We present three approaches that could reduce significantly the number of uninsured Americans (Table 3).

- *Medicaid Enrollment Outreach*—Though federal legislation has extended health insurance coverage to children under age 6 in families below 133% of the poverty level, and children through age 13 living in poverty, substantial numbers of these children remain uninsured. By one estimate, fewer than 50% of children eligible for these expansions have enrolled (data from *Current Population Survey*, March 1997). As a result, 6 million children remain eligible for coverage but are uninsured (see Table 2). Reasons for under enrollment are multifactorial and include poverty and illiteracy. The nation must develop educational techniques that help people learn about health problems and how to avoid them and about public health assistance programs that are available.

  Developing effective strategies for enrollment outreach remains an important strategy that could be pursued under current law. This strategy not only involves approaches for identifying eligible children but must also provide sufficient federal funds for undertaking these efforts. In Table 3 we outline the costs and impact of our proposal to provide additional federal financing to allow states to expand substantially their outreach efforts.

- *State Flexibility in Structuring Acute Care Services for Medicaid and the Poor and Near-Poor Population*—As noted above, the Clinton Administration has approved Section 1115 Medicaid program waivers for 13 states. Several other program waivers have been approved and are waiting for state implementation. A central feature of many of these research and demonstration waivers is Medicaid savings generated through the use of innovative approaches to the financing and delivery of services. When combined with the use of disproportionate share expenditures,[11] these program savings have been used to finance the expansion of coverage to currently uninsured persons. Of particular note is the fact that expansions of coverage have been accomplished within the projected baseline level of federal and state Medicaid spending—that is, with no new federal spending.

  Our proposed incremental approach would build on these state experiences and expand the spirit of the existing 1115 waiver process to other states. Along with the flexibility, states would be allowed and expected to enroll all uninsured adults initially living in poverty. Following this expansion, all adults up to 100% of the poverty level would become eligible for Medicaid. Adults living in families between poverty and 200% of the poverty line would be eligible for subsidized private health insurance coverage. Those subsidies would be provided as a fully refundable tax credit. The tax credits could be used to purchase a defined set of benefits provided through each state. The benefits could be modeled after the benchmark private insurance packages specified in the CHIP legislation.

[11]Disproportionate Share Hospital (DSH) Payment Program. Federal law requires state Medicaid programs to consider "the situation of hospitals that serve a disproportionate number of low-income patients..." in determining payment rates for inpatient hospital care. By applying to the federal government, states receive federal DSH payments to allocate to hospitals, in combination with a state share, either as lump sum payments made periodically or as add-ons to services. States determine which hospitals qualify as DSH program institutions, and only those hospitals can receive funds. Although total state and federal spending for the DSH program in Fiscal Year 1996 was $15 billion, not all these funds go directly to providers. The Balanced Budget Act of 1997 will require many states to restructure their programs and reduces federal spending over five years by $5.8 billion, according to simulations conducted by The Urban Institute.

As a result, when fully phased in, all children and adults living under 200% of the poverty level would be eligible for health insurance. As indicated above, this approach would build on models crafted by several states (e.g., Oregon, Massachusetts, and Tennessee).

This proposal assumes that states would generate savings when providing acute care services to current Medicaid enrollees. Additional costs of covering uninsured adults will be financed through tobacco tax and small contributions toward the cost of insurance by those newly

Table 3. Incremental Health Care Reform Options.

Design Feature	*Federal/State Approaches*	*Subsidies for Temporarily Employed Persons*	*Medicaid Enrollment Outreach*
Who is Eligible?	Uninsured adults under 100% of the poverty level eligible for Medicaid; uninsured adults at 101% to 200% of the poverty level eligible for refundable tax credit	COBRA-eligible workers and families; broader option would include those with unemployment spells; full subsidies would be available for persons below the poverty level, phasing out for persons at 250% of the poverty level	Uninsured children and pregnant women currently eligible for Medicaid
What Benefits?	Medicaid benefit package for those under the poverty level; private benchmark equivalent package under CHIP for 101% to 200% of the poverty level	Current employer benefits or, in broader option, those outlined under CHIP	Medicaid benefits
Federal/State/ Individual Contributions	Cost sharing for adults would be the same as outlined under CHIP	Advanced through unemployment compensation system; contribution based on annual income with reconciliation through Internal Revenue Service	Current Medicaid financing rules plus additional 100% federal funding to finance outreach activities
How Administered?	Broad federal guidelines, administered by the states; new flexibility combined with new efforts at enrolling children currently eligible for Medicaid	Employers and Internal Revenue Service	Current Medicaid administration
Participants (millions)			
Total Number of Uninsured	12	5.0	4.5
Uninsured Below the Poverty Level	8.5	—	—

Table 3. Incremental Health Care Reform Options—continued.

Design Feature	*Federal/State Approaches*	*Subsidies for Temporarily Employed Persons*	*Medicaid Enrollment Outreach*
Gross Federal Costs (FY 1998 – 2002) (billions of dollars)			
If family income is calculated:			
Annually	230	N/A	N/A
Monthly	276	30	20
Sources of Funds (billions of dollars)			
Premium Contributions	12	6	0
Tobacco Tax	50	19	15
Federal Savings	45	0	0
Disproportionate Share Offsets*	47	5.1	5
State Savings	44	0	0
Net Federal Costs (FY 1998-2002) (billions of dollars)	32-78	0	0

N/A: Not applicable for this option.
*Totals do not include disproportionate share spending in states with Section 1115 program waivers.

eligible. The cost-sharing rules would generally follow those established under CHIP.

- *Temporary Assistance for Workers Between Jobs*—One of the important incremental reforms passed during the past 15 years was the continuation of benefits under the Consolidated Omnibus Budget Reconciliation Act (COBRA). However, as noted earlier, relatively few persons eligible for employer-sponsored benefits actually participate in the program. A contributing factor is the affordability of health insurance. Qualified individuals must pay at least the full cost of the health insurance premium (but no more than 102% of the total cost). For most qualified eligible individuals, this represents a substantial increase in their direct out-of-pocket health insurance payment. Also, most workers qualifying for COBRA benefits were involuntarily terminated from their job. For many, the loss of employment means a reduction in take-home pay. Both factors contribute to the low number of persons participating in the program.

  One approach for addressing the affordability of COBRA benefits, as well as the benefits available to qualified persons moving from the group to the individual market under HIPAA, is to provide temporary federal financial assistance. For instance, time-limited federal assistance (e.g., up to 6 months) could be provided to qualified persons, based on their total income, to help with the purchase of health insurance. This assistance could be provided as a full federal subsidy for those with a monthly income below the poverty line, with federal support phased out at 250% of the poverty level.

Table 3 provides a summary of the key design features of each of these three proposals. It summarizes the newly eligible groups, the benefits they would receive, cost-sharing requirements, and program administration. The table also presents estimates of program costs and the expected number of uninsured enrolling in the program. Federal costs of the proposals are estimated over the next five fiscal years.

In addition, Table 3 presents some illustrative methods for financing these new federal costs. The sources of financing fall into three general groups. The first source is derived from monthly premiums contributed by those enrolling in the program. For each reform option, premium contributions would be related to family income. A second source of financing would be increases in the federal excise tax on tobacco. A third source is derived from savings generated from projected Medicaid spending (both federal and state) as well as converting a portion of disproportionate share subsidies to health insurance subsidies. With respect to the former, the recent experience with the Section 1115 Medicaid waivers in states such as Oregon and Tennessee provides some evidence that federal and state Medicaid savings can be generated when states are allowed program and design flexibility in their Medicaid programs. Oregon, for instance, has implemented some innovative approaches to prioritizing health care benefits and managed care. Savings generated using these approaches have allowed the state to expand Medicaid eligibility to over 100,000 previously uninsured residents. Similar savings in program spending have been estimated by nearly every state that has submitted more modest health care reform proposals (using the 1915-B waiver authority), allowing states to experiment selectively with other methods of delivering health care services.

Building on these diverse state experiences, we estimate that the remaining states, if provided similar program and design flexibility, could achieve similar levels of program savings. We estimate that these savings would be on the order of 15% of spending for acute care services currently provided by states that have not implemented a Section 1115 program waiver. The Medicaid savings that accrue to both the federal government and the states would be used to finance expanded health insurance coverage.

Finally, the illustrative estimates also convert a portion of Medicaid disproportionate share spending into health insurance subsidies for the uninsured. In concept, the amount of such payments converted to insurance subsidies should be proportional to the number of newly insured; that is, a percentage of the DSH payments would be freed up because formerly uncompensated patients would now have coverage. Federal DSH payments remaining in the pool could be targeted towards financing any remaining uncompensated care provided by hospitals.

Potential Number of Newly Insured, New Federal Costs, and Sources of Financing

A central focus for each of our incremental proposals is to limit enrollment to the currently uninsured. For instance, for each strategy, it is assumed that the eligible person must be uninsured for at least the previous 6 months and not be employed in a firm that offers or provides health insurance coverage. Assessing the health insurance status of applicants would be a substantial component of the implementation process. This section presents a brief discussion of the potential number of persons enrolling in each of the three incremental reform options. Despite the intent to limit enrollment to the currently uninsured, it is recognized that some persons—those with individually purchased coverage as well as some with employment-based insurance—will ultimately enroll. We recognize this possibility in our estimated federal costs.

Table 4. Estimated Number of Uninsured Individuals—Baseline versus Reform (Year 2002).

Uninsured Individuals—Baseline	
Number (millions)	41
Population (%)	15.7
Remaining Uninsured Individuals under Reform Options	
• Medicaid Flexibility Plus Children's Outreach	
Number (millions)	24.5
Population (%)	9.4
• Medicaid Flexibility and Children's Outreach Plus Workers Between Jobs	
Number (millions)	21.5
Population (%)	8.2

Another common feature across each of the options is the use of quarterly, rather than monthly, income to determine program eligibility. Monthly or quarterly income determinations would follow the approach currently used by the states when administering their Medicaid programs. This measure would allow the states to expand their existing administrative structure used to oversee the Medicaid program. An annual income test could be combined with this former approach, except that it would require an end-of-the-year reconciliation. As a result, the reconciliation would occur when policyholders filed their federal income taxes. Use of monthly income would enroll more persons in a typical month and result in higher costs relative to the use of a quarterly (or even annually) income measure. As the results displayed in Table 3 highlight, different time horizons used to determine program eligibility have an important impact on federal spending.

When viewed individually or collectively, the incremental reform options presented in Table 3 and summarized in Table 4 could provide a powerful approach for significant expansions of health insurance coverage. In short, implementation of outreach efforts to enroll uninsured children, combined with the Medicaid state flexibility approach would extend health insurance to 90.6% of the population. When combined with the option to include workers between jobs, the percent of Americans with health insurance could climb to 91.8%.[12]

Financing

Though several sources of financing could be identified for these expansions, we have focused on four sources summarized in Table 3: (1) federal and state Medicaid savings traced to the additional state flexibility, (2) reductions in the demand and need for disproportionate share spending, (3) premium contributions from enrollees, and (4) revenues collected from additional tobacco excise taxes.[13] These sources of financing for covering the uninsured are generally the same sources currently used in several states to accomplish similar objectives.

We expect states participating in the Medicaid expansion and refundable tax credit program to achieve many of the federal and state program savings already realized by states with 1115 program waivers. Moreover, some states have channeled most, if not all, of their disproportionate share spending into the purchase of health insurance. Several states have expanded the use of managed care, generated savings, and redirected those savings towards the uninsured. The two most notable states moving down this path have been Oregon and Tennessee.

[12]This conservatively assumes that only 75% of eligible adults receiving free insurance would enroll. Higher participation rates would reduce further the percent uninsured. However, because many workers between jobs are insured sometime during the year, they may not be coded as "uninsured" in the Current Population Survey and as a result may not be included in the base count of uninsured.

[13]We have assumed that prospective enrollees would finance approximately 10% of program costs. Though this proportion could be increased, it would reduce the number of uninsured persons participating. The excise tax would increase the tax on tobacco products to 99 cents per pack and would increase proportionately the tax on other tobacco products.

For example, the Oregon plan has prioritized health benefits, relied on managed care, and extended coverage to over 100,000 additional Medicaid eligibles. Though we do not assume this in our analysis, we have estimated the reduction in hospital-based uncompensated care resulting from the additional insurance coverage and translated this into a proportionate reduction in the need for disproportionate share funding. With these sources of financing, the remaining estimated federal costs range from $32 to $78 billion over a 5-year period.[14]

Though Medicaid savings are not sources of funding for the other options, a portion of disproportionate share spending could be redirected for use in purchasing health insurance. In this case, the remaining federal costs of the temporary assistance for workers would total $20 billion over the 5-year period, whereas the outreach efforts would require approximately $9.3 billion in federal funding. Of course, use of tobacco tax revenue in combination with the disproportionate share spending would fully fund each of these options.

Use of Disproportionate Share Payments

A key issue concerning our proposal is the conversion of hospital-based subsidies currently paid through the Medicare and Medicaid program into individual subsidies. We suggest placing federal disproportionate share spending on the policy table for financing incremental reforms for two reasons: (1) subsidizing individuals rather than hospitals is more direct, and (2) the current distribution is unevenly spread across the states. On its face, this conversion appears to be a more direct use of federal dollars—one that targets individuals in need rather than the institutions where they seek care. Subsidizing individuals rather than institutions would also ensure that federal dollars are distributed across the states according to need.

The federal government is expected to spend approximately $16 billion in federal disproportionate share payments to health care institutions during 1998. The distribution of these payments, in particular those flowing through the Medicaid program, varies widely across the states (Table 5) and appears poorly matched with the health care needs of the uninsured individual.

Table 5. State Distribution of Federal Disproportionate Share Spending Per Uninsured Individual (1995).

Disproportionate Share Spending Per Uninsured Individual (dollars)	*Number of States*
0	3
1–50	14
51–100	4
101–200	7
201–300	11
301–400	0
401–500	3
501–600	5
601–700	0
701–800	2
801–900	0
901–1000	1
>1001	1

From Thorpe, KE. Sources of Financing for Incremental Reform. Draft, Tulane University Summit on Public Health and Tropical Medicine, October 1997; with permission.

[14]Again, several states, such as Oregon and Massachusetts, have financed or intend to finance similar expansions of coverage at no additional federal cost.

For instance, federal disproportionate share payments are less than $50 dollars per uninsured individual in 17 states, yet they exceed $900 in two states. In 39 states, federal disproportionate share spending is lower than the national average level of uncompensated care spending per uninsured individual. The results presented in Table 5 highlight the substantial mismatch between the distribution of uninsured persons across the states and federal disproportionate share expenditures.

Though extending health insurance to low-income uninsured residents is more direct, redistributing federal disproportionate share dollars to finance these subsidies raises several concerns. The most important issue concerns the safety-net institutions that currently provide care to the uninsured and receive substantial support through the disproportionate share program. The issue here is whether these same institutions would receive reduced federal funds yet face the prospect of providing a similar level of charity care. This scenario would seriously compromise the financial condition of safety-net providers. Any proposal designed to convert a portion of disproportionate share dollars should be accompanied by a policy that more effectively targets the remaining disproportionate share spending toward hospitals that provide care for remaining uncompensated patients (e.g., undocumented immigrants). This "two-tiered" approach would, in effect, change the disproportionate share funding stream into an uncompensated care pool that targets safety-net providers.

Timing

Another critical issue concerns the timing of the proposals. Some of the proposed approaches could move forward immediately, whereas others could be phased in gradually. For instance, the Medicaid outreach efforts could be expanded as CHIP is implemented. Because CHIP contains several important new opportunities for enrollment outreach (i.e., presumptive eligibility for newly eligible children), these outreach efforts could be used to enroll children currently eligible for Medicaid.

The proposal to enroll workers between jobs could be implemented relatively soon as well. One of the sticking points here would be the set of benefits eligible persons would receive. There are two possible approaches that could be used. First, the federal government could establish a minimum benefit similar to the one outlined in CHIP. Alternatively, the federal government could allow the states to rely on the benefit package they have selected for eligible individuals converting from group to individual coverage as prescribed under HIPAA.

The expansion of coverage for adults could be phased in over 3 to 4 years. The first 2 years could expand Medicaid coverage to individuals below the poverty level. This strategy would allow the sequential testing of the refundable tax credit approach.

Conclusions

If pursued as a package, these reform options could extend health insurance to over 20 million Americans, increasing the percent of the population with insurance from 85% to 92% (see Table 4). These incremental strategies follow the same general approach recently agreed upon by the President and the Congress. Each option would establish broad federal guidelines outlining the scope of benefits to be provided and the population eligible for coverage. Actual program implementation, as well as key design issues and the precise set of benefits offered, would be established by the states. In essence, these approaches could easily build on the strategies and administrative structures currently under development for implementing CHIP. These approaches could be sequentially phased in, perhaps starting with outreach efforts to enroll currently eligible Medicaid children, followed by a 3- to 4-year phase-in of the state flexibility option (phased in by income) and the worker-between-jobs initiatives. This approach would allow each state to establish an administrative approach for the CHIP program that could serve as the basis for administering each of the subsequent incremental expansions of health insurance coverage.

We believe our federal cost estimates and sources of financing are realistic; they represent the same approaches currently used by several states seeking to achieve similar health insurance expansion goals. In sum, the bipartisan political agreement surrounding the method of financing and administering a major expansion of health insurance for children living in families under 200% of the poverty level could serve as a model for extending the same opportunity for health insurance coverage to their parents.

The American College of Physicians is committed to reaching the goal of 100% of Americans having health care insurance coverage. We are realistic, however, that the goal will not be achieved in a single piece of legislation. It is critical to move forward. The proposals we have outlined would extend coverage to about half of those people currently uninsured, so that approximately 92% of the population would be insured. We look forward to the day when that level is achieved, so we can return with further proposals that will achieve universal coverage early in the next century. As we have stated before, this goal is a moral and medical imperative for this nation.

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